CENTERS FOR MEDICARE AND MEDICAID SERVICES
10th National HIPAA Implementation Roundtable
Conference Call
06/25/03

Operator: Good afternoon. My name is Kimberly and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services 10th National HIPAA Implementation Roundtable. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question and answer period. If you would like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you. I would now like to turn the call over to Dr. Bernice Harper.

Dr. Harper: Thank you, Ms. Nelson. Good afternoon to those of you on the East Coast, and good morning to those on the West Coast. It is my pleasure to serve as your moderator this afternoon. This roundtable call is being conducted by the Centers for Medicare and Medicaid Services, or CMS, which is part of the Department of Health and Human Services. Our subject today is the Health Insurance Portability and Accountability Act of 1996, or HIPAA, and specifically the administrative simplification division.

I'd like to share an experience I had with you this past week. I went to my physician and as I sat in the room, the receptionist came to me and said, I'd like you to sign these HIPAA papers. I had a real experience. So now I am a part of the real HIPAA world. It was very real, and I can assure you that it didn't take me a long time to fill out the papers. And I wanted to share that experience with you.

Now we will begin our call with a few words from Ms. Karen Trudel, the Deputy Director of the Office of HIPAA Standards at CMS. Ms. Trudel?

Ms. Trudel: Thank you, Dr. Harper. In the 113 days left between now and October 16th, the healthcare industry as a whole will have to

address the challenge of becoming HIPAA compliant with the transaction and code set standards. I think we all realize that effective October 16th administrative health transactions that are done electronically must meet HIPAA standards for format and content. To ensure there is a continuation of payments between plans and providers, it is critical not only to be HIPAA compliant, but to have tested with your trading partners in advance of the October 16th deadline. It is important for everyone to assure that they not only are able to send compliant transactions, but that their trading partners can expect these transactions and process them. Providers can test by submitting transactions they believe to be compliant to the health plans they bill. The plan then determines whether they can read and process the claim. If the plan identifies problems, they will be communicated back to the provided, the errors identified and additional testing would occur. Don't wait until the last minute to test. Testing can take time, and as the deadline draws near, plans testing resources will be stretched thin. Medicare contractors are ready to test now. You can call your contractors and schedule testing, or ask your clearinghouse or billing service to do so. And we'll have an update on Medicare's readiness in a few moments.

Many people have asked recently whether the Department of Health and Human Services will provide any relief from the October 16th deadline. There are lots of rumors going around that there will be additional extensions, etc. The short answer is no. The HIPAA statute and the regulations require all transactions to be conducted with the standards effective October 16th. No matter what anyone may have heard, covered entities should still be preparing their operations to meet that requirement. The Secretary of Health and Human Services has been asked to alleviate situations where entities that are still in the process of complying might have their cash flow interrupted. The Department is still assessing these requests and other possible options. No decision has yet been made whether any action at all will be taken. So again, I suggest be sure to be moving toward a compliance date of October 16th.

Now we're going to go on in a moment and have an update on Medicare from Janice Nero-Phillips. I'd like to tell you in advance that we do have representatives from the Office for Civil Rights on the line to take your privacy questions. We thank Kristina Sandoval, Kathleen Fimple and Bill Reinhardt for being with us

today to respond to those questions as they come up. And now we'll have the Medicaid update from Janice Nero-Phillips.

Ms. Nero-Phillips: Thank you, Karen. I wanted to give you the latest status on Medicare fee for service and the HIPAA readiness for Medicare. As Karen mentioned, open trading partner testing has begun at the majority of the Medicare contractors nationwide. And to date the majority of contractors are ready to test on the latest HIPAA format, or the 40-10A version. There are just a few contractors who are busy implementing the 40-10A version over the next week or two. So we urge you to contact your respective contractor, your fiscal intermediary or carrier to find out about their specific current testing status.

Medicare contractors began reporting the status of submitters in testing and in production in September of 2002. Our contractors also submit monthly reports showing progress of the implementation of the HIPAA format. The majority of contractors are ready to test on the 837 inbound and outbound plan. Our contractors also submit monthly testing reports, and they show the progress of the implementation of the HIPAA format. The majority of contractors are ready to test on the 837 inbound and outbound claims, as well as the 835 remittance advice. However, currently only 7% of all claims submitted to our contractors are now in the latest 40-10A HIPAA format. Just to give you a few statistics, as of June 6th of this year, there were only 10,000 submitters in production on the latest HIPAA version 40-10A for the 837 inbound claim. And this is out of a total number of 155,000 submitters. So we really urge you to contact your contractor as soon as possible to arrange a date to begin testing on this current HIPAA format if you have not already done so. The HIPAA deadline for transactions and code sets -

Ms. Nero-Phillips: Okay. I'll proceed with the Medicare update. And the deadline for HIPAA transactions and code sets is October 16, 2003 per ASCA. And Medicare will only accept claims in the current HIPAA format, the 40-10A format, come this date. Please call my office at 410-786-1785 if you have any questions. Thank you.

Dr. Harper: Okay. Thank you, Janice. Now we're ready for the questions. Ms. Nelson, would you give the instructions so that we can ask the questions and we can answer the questions?

Operator: Yes, ma'am.

Dr. Harper: Thank you.

Operator: At this time I would like to remind everyone, in order to ask a question, please press star, then the number one on your telephone keypad. Your first question comes from Caroline Price.

Ms. Price: I apologize. My question has to do with the transactions and trying to get a question answered about them. It doesn't have to do with Medicare.

Ms. Trudel: That's perfectly okay.

Ms. Price: Okay. I sent a message in to ask HIPAA – we're having a problem with the 837I. The loops are 23-10A for attending physician and 23-10B for operating physician – have been removed, but the information regarding the other provider is still in there and it doesn't make any sense. And I'm trying to find out why it's there.

Dr. Harper: Someone is coming to the phone to answer it.

Ms. Glass: Hi, this is Joy Glass. You're saying – this is in the addenda, the A1?

Ms. Price: Right. The addenda removed the 23-10A and the 23-10B but the 23-10C for other providers, specialty information is still there and it's not logical. And I'm trying to figure out whether that's an error. I see no validity for that information if the attending and the operating physician have been removed.

Ms. Glass: Okay. We can check on that and give you a call back if you're willing to provide your name and phone number.

Ms. Price: My name is Caroline Price, and my phone number is 707-738-6873. And we need that answer desperately, so I'm more than willing to do whatever it takes to get it.

Dr. Harper: Thanks, Ms. Price. Next question please.

Operator: Your next question comes from John Cody.

Mr. Cody: Hi. There are still reams of questions I think under the privacy rule in particular, but also some of the other rules which have not been answered yet. Our office has sent several questions going back to December 2001 to DHHS, which we haven't received responses on. I know OCR's What's New website has not been upgraded since April of this year. And I'm wondering if you can give an explanation of what kind of guidance on the privacy rule and also on the other rules that we can expect in the next few months? And also if there is a more effective mechanism for getting our questions responded to than sending them to the HIPAA in boxes on respective DHHS websites where some of these questions seem to languish for some point in time. Thanks.

Ms. Trudel: Well, I'll start and then I'll turn it over to Kristina and her colleagues to talk about privacy. This is Karen Trudel again. We are at this point responding to questions that we get in the Ask HIPAA mailbox as quickly as we can in the order of receipt. (**askhipaa@cms.hhs.gov**) You have to understand that some of the questions are fairly easy to respond to, some require a great deal of research, and some we essentially cannot respond to at all because they're asking for almost a legal opinion of a specific situation. So while I have to admit that we're not doing a really fast turnaround, we are plowing through the ones that come to Ask HIPAA. I know that there used to be a mailbox at the Department for sending in questions, and I don't believe anyone is staffing that one anymore.

Male Speaker: Those automatically get forwarded to Ask HIPAA.

Ms. Trudel: I'm sorry. They get forwarded to Ask HIPAA as well. And again, as I said, we answer them as quickly as we can in the order of receipt, and based on our manpower limitations. I would ask the Office for Civil Rights, if they want to respond with respect to privacy guidance.

Ms. Fimple: This is Kathleen Fimple. With regard to the guidance on our website, it is being updated as expeditiously as possible. The questions that come in, if there are enough questions on a particular topic, they do an FAQ, but it has to go through a rigorous clearance process within the Office of the Secretary before they're posted. We do have a toll free hotline number that you can call into, and the questions will be fielded out to the

appropriate regional office, and someone will get back to you in usually three to four days, and can discuss the questions with you. It is our agency's position that we are not providing any legal opinions or advisories to your specific – your fact specific questions, but we can guide you through the regulation and the rule to help you determine what you need to do to comply with the privacy rule. The toll free number is 1-866-OCR-PRIV.

Mr. Cody: Okay. Thanks. And that makes sense obviously that you can't respond to fact specific questions. Some of the questions which have been languishing are questions which seem like they would be more readily respondable to than other questions. I'll just give you an example. Is death included amongst the general conditions for which our covered entities can disclose as a condition of severity of somebody's medical condition or what have you when they're in the hospital? That seems a relatively straightforward question. I know it's been a question that's been out on the list servers quite a bit. Again, would you recommend re-posting these questions, either phoning this telephone line, or re-sending them to Ask HIPAA if they've been languishing for some time?

Ms. Fimple: Call the toll free number.

Mr. Cody: Call the toll free number? Okay. Thank you very much.

Ms. Fimple: Okay.

Ms. Trudel: This is Karen again. I'd like to clarify that the Ask HIPAA e-mail resource is for non-privacy issues only. We can't answer privacy issues because it's staffed by CMS staff. And I would mention for those who aren't aware of it that we too have a hot line for issues that do not relate to privacy, and that's 1-866-282-0659. Thank you.

Mr. Cody: Thank you.

Dr. Harper: Next question please.

Operator: Your next question comes from Cindy Glass.

Ms. Glass: Has there been any ruling on how we could handle claims that are currently required to go paper to the intermediary that says they require operative reports and additional medical information, etc.?

Male Speaker: That's in regards to the Medicare electronic billing requirement which will be effective October 16th. There will be some regulations issued on those hopefully within the next month or so that will detail not only the exception for small providers, but other situations that may be exempt from the electronic billing requirement. So when that regulation gets published, you'll be able to see what the other situations are.

Ms. Glass: So you say that should be available in the next 30 days?

Male Speaker: I can't guarantee that. The expectation is sometime towards the end of July.

Ms. Glass: Okay.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Denita Hernandez. Ms. Hernandez, your line is open.

Rhonda: Hi, I'm actually Rhonda, but I have several questions. The first one was in regards to the paper claims as well, and it has to do with the additional documentation requests. Will they still accept paper? The second one is will all of the transactions be implemented on October 16th or the companion transactions be implemented at a later date? And if so, when? And then I think you just answered my question about the special circumstances on paper claims.

Ms. Trudel: This is Karen, and I'll take them in reverse order. The HIPAA deadline applies to all of the transactions, so that includes the claims status, query and response, the eligibility transaction, the premium payment, all of them. The compliance date is the same. With that having been said, however, while plans must be able to be ready to accept all the transactions on that date, providers don't necessarily need to implement them all at once. In fact, a number of health plans have been sequencing those transactions into production, but the intent is that all of the transactions should be implemented by the October 16th compliance date.

Again, going back to your question about the paper claims. Because there is a regulation in process and it's still being

reviewed by the Secretary, there's a limit to what we can say about the content of that electronic billing rule, whether it applies to a field claim or whether it applies to claims that require paper documentation. And all I will say is that we did go through a fairly rigorous process of trying to identify all the situations where we felt that paper claims were still needed in the course of developing that regulation. And I'm sorry, that's about all I'm able to say about it right now because it is still in review.

Rhonda: Okay. I have one additional question. In the last roundtable discussion we talked about if you had a paper attachment you would indicate that in the PWK field of the 837 transaction, and then actually mail the paper document along with it. How will CMS match those up once you receive the paper that is indicated in the PWK field? Is there a procedure, and if so, are there instructions published? If not, when and where can we find it?

Ms. Glass: Hi, this is Joy Glass. And there is a document control number – a control number. I can't think of the exact name of the field that you would put on the electronic claim, and then you would actually have to put that on the paper attachment so it could be linked up once received by the CMS contractor.

Rhonda: Okay. So there's a document control number listed on the transaction?

Ms. Glass: Correct.

Rhonda: Okay.

Ms. Glass: And it's called an attachment control number or something like that.

Rhonda: Okay.

Dr. Harper: Thank you. Next question please.

Operator: The next question comes from Cindy Aaron.

Dr. Harper: Ms. Aaron?

Ms. Aaron: Hi. Sorry. Thank you for taking my call. I have a lot of providers that are still concerned about some lab codes that are not going to be ready to go and so forth. Have you researched any more of that?

Female Speaker: Are these local codes?

Ms. Aaron: Yes.

Female Speaker: The local code issue – if you're talking about Medicaid, is one that's a state by state issue.

Ms. Aaron: I can contact them then.

Female Speaker: Yes, that would be the best idea because we're hearing that some states are not having very much trouble converting local codes, and others because they have so many of them do have some problems.

Ms. Aaron: Okay. And then is there a website that is posting the name of the carriers that have – the clearinghouses that have tested already?

Female Speaker: Yes.

Ms. Aaron: I understand that that is optional, correct? They do not have to post it?

Female Speaker: No, they are required to post the name of any clearinghouses, etc., that have moved into production on the HIPAA transactions.

Ms. Aaron: Okay.

Female Speaker: And that is on our website, www.cms.hhs.gov/providers -

Ms. Aaron: Yes, I have been on that, but I had heard that it was not mandatory. But it is mandatory then and they will be listed?

Female Speaker: Yes. The advice is there for the majority of them. If you get on that source page and you get to that page, the bottom of that page, you click there if you want a list of the vendors, and it will bring up each state, and you click on that state, and that will link you to those vendors.

Ms. Aaron: Okay. Thank you very much.

Ms. Trudel: And this is only for Medicare?

Female Speaker: Right.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Marty Bolden.

Mr. Bolden: Hello?

Dr. Harper: Yes?

Mr. Bolden: Okay. Sorry. Never done this before.

Dr. Harper: That's great.

Mr. Bolden: I think my question probably isn't right for this committee, but since we called in we thought we would ask this anyway. Thank God we're asking for a legal opinion here and I'm guessing that this isn't the right place to do that. But if I could just ask the question, that would be great.

Dr. Harper: Go right ahead.

Mr. Bolden: Thanks. We are a small community based health center, and we have recently been awarded a grant to implement an electronic medical record. And that electronic medical record allows registration information from provider to provider to be kind of shared throughout anybody who is on that system. And what has happened now is that when we search for our client, we pull up a whole list of information about peoples' names, addresses, so on and so forth that we would kind of move into our client set. And our concern is that we're not sure whether or not that's compliant with HIPAA, and we can't seem to get a clean, clear answer about that anywhere.

Ms. Trudel: Do you mean with respect to privacy?

Mr. Bolden: Yes.

Ms. Trudel: Over to you, OCR.

Mr. Bolden: Say it again?

Ms. Trudel: I'm asking the OCR folks if they would like to take a shot at that answer.

Female Speaker: Just give us a moment to confer here.

Ms. Trudel: Thank you. Okay.

Mr. Bolden: What does OCR stand for?

Female Speaker: Office for Civil Rights.

Mr. Bolden: Thank you.

Ms. Fimple: Okay. This is Kathleen Fimple. Just to clarify, the information is being shared between one provider to another provider?

Mr. Bolden: Yes. I think we might be in the right place, so let me get a little more specific. Specifically, our agency serves a lower income client. And when they're entered into the system, they get an ID number that identifies them with our agency. And our concern is specifically if they seek services at another provider that is also using that electronic medical record, that the information that comes up about us about them being our client would in fact kind of violate the confidentiality.

Ms. Fimple: Well, you can share information for purposes of treatment from one provider to another provider without authorization from the patient.

Mr. Bolden: Okay.

Ms. Fimple: Okay. Do you want the citations on that?

Mr. Bolden: Sure.

Ms. Fimple: Okay. 164.502A1, small Roman numeral two. The covered entity may not use or disclose protected health information except as permitted or required by this sub-part. And then it goes into a covered entity is permitted to use or disclose protected health information as follows. Small Roman number two reads, for

treatment, payment or healthcare operations as permitted by and in compliance with 164.506. So without getting into further discussions, you can review that in the privacy rule. And if you have more specific questions, I would say to call the 1-866-OCR-PRIV number, and someone will call you back and walk you through it.

Mr. Bolden: Thank you very much.

Ms. Fimple: This is Kathleen Fimple still. I would like to respond on the previous question, and just give the caller a citation on the question about disclosing information regarding death, and that is 164.510B1, small Roman numeral two, which reads, a covered entity may use or disclose protected health information to notify or assist in the notification of – I'm taking it out of context a little bit – a family member, a personal representative of the individual, or another person responsible for the care of the individual, of the individual's location, general condition, or death. But, of course, then you have to take it one step further and do it in context with the additional paragraphs, which I'll let you read. But if you have additional questions, call the 866 number.

Dr. Harper: Thank you very much. Next question please.

Operator: Your next question comes from Carol Zunigy.

Mr. Tool: Carol didn't ask the question, I did. My name is Rich Tool. I deal with retail pharmacy. One of the questions I had is Medicare – or do Medicare have any plans to accept an NCPDP version 5.1 transaction real time? Or are all the transaction code sets going to have to come in in the NCPDP version 1.1? One of the concerns that the retail pharmacy entity has is the reimbursement and guarantee of payment. If it has to come in on a batch transaction in NCPDP version 1.1 or in a supply setting in the 837, we're not going to know whether the claim is rejected or paid prior to the 835 payment remittance coming back in. Are you planning on or setting up for NCPDP version 5.1 real time format?

Ms. Glass: Hi, this is Joy Glass. And at this time, no, we are implementing the batch orders on point one. We do not support online real time claim submission.

Mr. Tool: How are they going to handle then non-payment if claims?

Because the pharmacies are going to have a lot of product out there that may be covered – may or may not be covered under Medicare?

Ms. Glass: You will be getting the 835 remittance advice back on the batch of claims that are submitted. Basically this is going to continue to operate the same way it does now, except that we will accept a fee claim by NCPDP batch instead of international standard format or on paper. This is the environment that suppliers and pharmacies are used to dealing with in the Medicare arena.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Carl Russell.

Mr. Russell: Hello. I work for a dental health plan payor. For years we've been using the current dental terminology codes, but we've added a few unofficial codes over the years too for procedures that we do locally here that aren't part of the CPT codes. But also there's codes that have been dropped over the years too as we moved from older version of the CPT to the newer versions. And when a claim comes in that contains one of those older codes that we don't use anymore, we just simply deny that detail line on the claim as using the wrong code. So if the EDI standards require that we only use the official CPT codes, and currently CPT4 codes as of the first of the year, then we kind of have a problem. We don't know how to respond to that claim status request that we might get and display the procedures – all the procedures on the claim if some of those procedures are invalid and not part of the current accepted codes allowed under HIPAA. If we don't display those lines as they were submitted, then we're altering or we're not providing the correct or complete information about the claim when it was properly requested as we should under the HIPAA regulations. And so we have to send all of the information complete and correct, but we're not allowed to send the information complete and correct because it violates the code sets part of the standard. Sort of a catch 22 situation. We're in violation if we don't give the patient all the information, and we're in violation if we do. So what's the answer?

Male Speaker: You are detailing a situation where the provider sends you a claim with an invalid code?

Mr. Russell: Yes.

Male Speaker: And you need to report back that they have an invalid code?

Mr. Russell: Well, this may be six months later they may send in a claim status request. They may send us – what's the status of a particular claim, and that claim was long since processed and paid. And now we just want to regurgitate that information back to them electronically.

Male Speaker: Yes, I understand. The rules allow you to use the version of the diagnosis or procedure codes that were in effect at the time the service was provided. So if they sent in a claim with a code that was valid during a past time period, you can report that code back to them.

Mr. Russell: That will actually handle those codes that were actually valid at that time, but if they send in a code that is invalid, we simply deny it because it's invalid, but that is now part of the history of that claim, that the procedure code that they send in is not a valid procedure code, we deny that line because it's invalid, and then there's three or four more lines that are valid on the claim that we actually pay on. So the whole claim may have five lines on it. The first one is invalid, the other four are just fine. We pay the whole claim, and six months later they go, what's the status of that claim, and we send back five lines. Four of the lines have valid procedure codes and one has an invalid one that we're not allowed to display because it was invalid. It was never valid.

Female Speaker: I think as long as you have – and I'm not clear on the claim service response – but if you have your reason codes for denial that says you actually denied that, then that would be considered that you denied that because it was an invalid code.

Mr. Russell: There are certain fields that we're allowed to break from the code set requirements. There's certain exceptions to that code requirement. You're saying this would be an exception?

Female Speaker: Yes, it's the same thing, for example, on 835 you need to send back, which claims were denied, and therefore the invalid codes. And that's going to happen. We do understand that's going to happen.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Lisa Darska.

Ms. Darska: Thank you. My question relates to the 834 transaction and the use of a field. If a health plan places information in a field that is defined in the implementation guide as not used, would using this field to pass information on to a subcontractor render the transaction non-compliant?

Mr. Nachimson: This is Stanley. It depends on if you are doing it to actually conduct a transaction or simply to pass information on to a subcontractor for use at a later time. The implementation guides and the rules have to be used when you're actually conducting the transaction. So it would depend on the relationship between the health plan and the subcontractor. If the purpose of the transaction was actually to do enrollment from a sponsor to a health plan, then that field could not be used. If the 834 had been already received by the health plan from a sponsor or another health plan indicating the enrollment transaction, and then the health plan was merely processing that enrollment, passing that information along to its subcontractor, you could use the not used fields or modify the transaction any way you would like.

Ms. Darska: Great. Thank you very much.

Dr. Harper: You're welcome. Next question please.

Operator: Your next question comes from Keith Suglisi.

Mr. Suglisi: Hi. Thank you. I have a question relating the DDE, the direct data entry. There are some community physicians who do not send any electronic transactions at all, but they have a computer in their office, and they will visit a health plan website to verify eligibility for a patient let's say. Now is use of that type of DDE, a health plan website, in and of itself enough to cause a physician to be considered a covered entity?

Mr. Nachimson: In general, yes.

Dr. Harper: Thank you.

Mr. Suglisi: Can I ask one more question?

Dr. Harper: Surely.

Mr. Suglisi: It also relates to the DDE. In the regulation it states that the DDE can be used in place of a transaction, like a claims status transaction. It says that the DDE would not need to be data format compliant, but it would need to be compliant in terms of data definition?

Mr. Nachimson: Data content.

Mr. Suglisi: Oh, data content? What does that mean?

Mr. Nachimson: That means that the data elements that are present in the EDI transaction have to be present on the DDE screen, and the DDE transaction and the conditions for use have to match those conditions that are present in the EDI transaction.

Mr. Suglisi: Thank you.

Dr. Harper: You're welcome. Next question please.

Operator: Your next question comes from Joe Murphy.

Mr. Murphy: This is Tenant Health Systems. In our research to establish what transaction data elements will be required from our facilities, clinical systems in order for 114 hospitals to be compliant, we found that identify and address information for all site labs are in the implementation guide as situational. My understanding of the term situational is that if the situation of an outside lab charge occurs, these ATDE's are required. That series is identified in the 837I implementation guide on page 349 as the 2310E loop. Some of the lab applications and HIS vendors we have spoken to say they are accommodating that loop. Others including some of the largest have said they are not. My question is do we have to be able to get this information into our billing systems from our lab systems or not? Does situational actually mean optional or required? If this question can't be answered on this call, who is the person that we go to for a definitive answer? And has any one of the other participants addressed this issue?

Mr. Nachimson: Let's try and answer the general question. Situational does not mean optional. It means, as you stated in the beginning, if the

situation is met as defined in the implementation guide, you must have that data element in there. If the situation is not met, then you don't need to have that data element in there. So the fact that these other vendors are not supporting it is certainly a little disconcerting. It would be a requirement on the hospital to be able to fill in that data element if the situation is met. I think if you want some further definition on that, and if you need us to perhaps go into some more detail, feel free to call – do you mind me giving out my number? I'd be happy to talk to you about it. This is Stanley Nachimson, and I'm at 410-786-6153.

Dr. Harper: Did you get it, Mr. Murphy?

Mr. Murphy: Yes. Now how do you spell his name?

Mr. Nachimson:: N-A-C-H-I-M-S-O-N.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Cazu Suna.

Mr. Suna: Hi. This is a privacy rule question specifically regarding the covered entities' responsibility as to the notice of privacy practices after there is a material change. So Regulation 164.520B3 says generally that a covered entity has to promptly revise and distribute its notice whenever there is a material change. So my question is, for instance, the following section has specific requirements for specific types of covered entities. So, for instance, a healthcare provider with a direct treatment relationship only needs to make the notice available on request and post the revised notice. But it would seem then that a healthcare provider with an indirect treatment relationship, like a pathologist or something, then falls under the general revisions to notice section. And so it seems to say that the healthcare provider with an indirect treatment relationship has to distribute the revised notice. And I'm wondering about the sort of disconnect between that. So the healthcare doctor who actually sees patients face to face only has to make the notice available on request because of a specific provision, whereas the physician who does not have face to face contacts with a patient seems to have to distribute the notice.

Ms. Fimple: This is Kathleen Fimple. An indirect treatment provider does not have to distribute the NPP at any time. They just have to have it

available if someone asks you for it.

Mr. Suna: Okay. So then the two healthcare clearinghouses have to – I guess my question is this Section 164.520B3, the revisions to notice, the covered entity must promptly revise and distribute its notice whenever there is a material change. So does that section only apply to healthcare clearinghouses given that the next section has specific requirements for health plans and healthcare providers with direct treatment relationships?

Ms. Fimple: Just give us a moment here.

Mr. Suna: Sure.

Ms. Fimple: We're just conferring on the question here. A healthcare clearinghouse does not have to provide an NPP.

Mr. Suna: Okay. Then who does that section apply to? What covered entity does that section apply to?

Ms. Fimple: Direct healthcare providers and health plans.

Mr. Suna: But direct healthcare providers are covered in the following section. In other words, 164.520C2, little Roman numeral four, says whenever the notice is revised, make the notice available on request on or after the effective date of the revision. So that's what a healthcare provider with a direct treatment relationship has to do?

Ms. Fimple: Yes.

Mr. Suna: Okay. And then likewise, C1 has a section that talks about what health plans have to do after the notice is revised. So I'm confused as to what B3, the prior section that just talks about covered entity must promptly revise and distribute its notice whenever there is a material change. To what types of covered entities does that general section apply?

Ms. Fimple: One moment.

Ms. Trudel: Perhaps we need to go on to the next question, and when the OCR staff has that answer ready, they can break in between questions.

Ms. Sandoval: I'm sorry. We can answer that now.

Ms. Trudel: Okay.

Ms. Sandoval: This is Christina. I just wanted to clarify. I think that the gentleman is looking at C1, specific requirements for health plans, and thinking that that is part of revisions to the notice. Three, revisions to the notice is a general part of the section – C is then entitled, implementation specifications, provision of notice, and those are the exact directions as to how the covered entity is to provide notice – initial notice.

Mr. Suna: And where does it tell us that – when revisions to notice says the covered entity just generally must promptly revise and distribute – what section tells us that healthcare providers with indirect treatment relationships and healthcare clearinghouses do not fall under the term covered entity as used in that particular section?

Ms. Sandoval: Well, actually, I don't believe there is anything in the regulation that necessarily speaks to indirect treatment relationships. That is in the preamble actually, and I don't have that available with me right now, and I would be able to give you that page number.

Mr. Suna: Okay. So just to clarify then, the B3 is just sort of sitting at the general principle that covered entities must revise and distribute the notice whenever there's a material change. That section only applies to health plans and healthcare providers with direct treatment relationships, and the way that they distribute is the way that's set out in Section C?

Ms. Sandoval: Exactly.

Mr. Suna: Great. Okay. Thank you.

Dr. Harper: You're welcome. Next question please.

Operator: Your next question comes from Jackie Pender.

Ms. Pender: Hi. We're calling from a software vendor, and we have a question. Last month when this whole conference took place, there were some questions regarding the 835 remittance, and how to test those transactions back into the 837 claim. And we were told at that time that we're not able to do that at that time – at this time. And

when I called Medicare, one of the fiscal intermediaries, I was told that instead right now we can only take an existing remittance file and have it converted to an 835, and then take that file and do internal testing without having a coordination of benefits back through to the 837. Do you have a timeline of when we can do real testing with the 835 and 837?

Ms. Glass: This is Joy Glass. It sounds like you're talking that you want to do end to end testing?

Ms. Pender: Yes.

Ms. Glass: Our contractors don't perform the end to end testing. And basically what you need to test is to make sure that you can create and the contractors can receive that 837, and that you can receive an 835. But we're not testing that that 837 actually adjudicates and pays, and how their system is set up. A lot of these files aren't necessarily in the test system, and that's the reason why they don't do end to end.

Ms. Pender: So there are no plans to do an end to end test then for service?

Ms. Glass: Not at this time, no.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Tyler Faircloth.

Ms. Faircloth: My question regards the Medicare secondary claims. Has the decision yet been made whether Medicare secondaries are required electronically or if they can be submitted on paper?

Mr. Nachimson: That again refers to the Medicare electronic billing regulation, which will be issued sometime in the next month or so. And unfortunately, we can't give you any information on that until that regulation is published.

Ms. Faircloth: Okay. Once that regulation is published, how long will we have to get that in place?

Mr. Nachimson: Secondary claims require electronic billing. You'll have to do that by October 16th, but there's no guarantee that they will or they won't require electronic billing at this point.

Ms. Faircloth: Thank you.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Lisa Scott.

Ms. Valentine: Hi, this is Lori Valentine from Sacramento County. A while ago there was an e-mail that went out to the NMEH, the National Medicaid EDI HIPAA work group from David Greenberg regarding Medicaid local codes. And basically they were saying that they were going to extend the usage of that until 12 –03 And then later, NMEH called and CMS said, yes, that's a done deal. It's okay. We were hearing rumors that some of the clearinghouses and translators were not going to accept that as a formal – because it didn't really come from formally from CMS. Do you understand the question?

Mr. Friedman: Yes. This is Rick Friedman at CMS with Medicaid. I think you sort of broke in and out, but I think the essence of your question was it didn't seem that an informal phone conversation was sufficient for certain folks, and that you would prefer, or they would not really be willing to behave that way unless it was something formal coming from CMS.

Ms. Valentine: Yes.

Mr. Friedman: We understand your question. I'll look into it and see if we can do that. I'm not sure the extent to which we're able actually to send something formally and get it out quickly, etc. But what we could do to facilitate that, we would.

Ms. Valentine: Thanks.

Ms. Trudel: This is Karen Trudel. If all else fails, we could put it on frequently asked questions. We do have a legal opinion on that. And I would hesitate – I would hasten to point out to people that this is not an arbitrary extension that we're granting to states. This is something from a separate piece of legislation that requires Medicare and Medicaid local codes to continue in place for an additional quarter after the current HIPAA compliance date.

Ms. Valentine: The ITA or –

Ms. Trudel: Something like that.

Dr. Harper: Thank you.

Mr. Friedman: This is Rick again. I just wanted to follow-up. Perhaps the best way to send a message back formally is back to the NMEH. Because one of the issues is sort of who needs this information and they're all over the country. So if we went at least to the NME and we went through the frequently asked questions, that would be two different ways to get the word out.

Ms. Valentine: I think NMEH is agreeing. I think it was just some of the bigger clearinghouses that said the only codes that they have on their list are the national CPT's, which those local codes would be cut off as of 10/16.

Mr. Friedman: Right. I wasn't suggesting that NMEH wasn't agreeing with it. I just thought there might be a vehicle to get the word out.

Ms. Valentine: Yes. Thanks.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Desla Mancilla.

Ms. Mancilla: Hi, I have a taxonomy code question. The revised listing of taxonomy codes that was issued in April of this year does not seem to accurately describe some of the specialties. For example, we were previously in a live production environment with Med B, and our claims were being accepted. Now since we have the revision of the taxonomy code list, our claims were being rejected because of the taxonomy code. When we tried to replace the taxonomy code for physicians who are reading EKG's, there are only three taxonomy codes that can potentially apply. One of them for invasive cardiology doesn't work. One of them is for pediatric cardiology and it doesn't work. The only one that would be a technician, and a physician is not a technician. So I'm concerned about how we can really classify correctly specialties when we don't have a taxonomy code list that allows us to do that. And in conjunction with that, Med B says that the 40-10A1 version does not look at the taxonomy codes, and so they suggest that we use a generic taxonomy code. And, of course, we're hesitant to do that

without really understanding who needs these taxonomy codes and what they're really being used for.

Mr. Nachimson: By Med B, are you referring to Medicare Part B carrier?

Ms. Mancilla: Yes.

Mr. Nachimson: Let me suggest that, first of all, if you have a concern about the taxonomy codes, there's an opportunity to request additional taxonomy codes. I think they're being supported through the Washington Publishing Company website. And I would suggest going there and putting in a request for additional taxonomy codes if you feel the current list does not satisfy your needs. And I'll let the Medicare folks talk about the use of the taxonomy codes in the Medicare submissions.

Female Speaker: We don't use the specialties. There would, of course, have to be a valid code on that. So we do not, at least on Medicare, we do not use a special C code for any type of processing. We have our provider files which we look at, but we do not use the -–but it still has to be a valid code.

Mr. Nachimson: So at this point, would it be okay if during the process of requesting a better taxonomy code to use the generic taxonomy code for submission to Medicare?

Ms. Trudel: This is Karen Trudel. Could I ask, what actually is the specialty of the physician who are reading the EKG? Are they cardiologists?

Ms. Mancilla: Yes, they are.

Ms. Trudel: And there's no taxonomy code for cardiologists?

Ms. Mancilla: No. There's an invasive cardiology activity, pediatric cardiology and technician. On the previous version there was a generic cardiology taxonomy code. On the revised list, there is not.

Ms. Trudel: You may have uncovered an error.

Ms. Mancilla: Okay. Great. Thank you. I have one other quick question regarding drug codes. Our understanding was that the NDC and J codes would only be required for retail pharmacy claims. And our Medicaid contractor at a meeting recently said that we will have to

have a drug code for every drug used, even aspirin, for all claims, not just for retail pharmacy claims. Can you clarify that please?

Mr. Nachimson: Retail pharmacy claims must use the NDC code referring to drugs. Other claims, there's no standard that has been adopted for those, however, the implementation guide allows the use of J codes with the addition of NDC codes, and the payor is free to require the use of the NDC code along with the J code if necessary according to state law. So Medicaid state agencies can require the use of the NDC code, and the NDC to be added to those claims.

Dr. Harper: Thank you.

Ms. Mancilla: And that is only for –

Dr. Harper: Go ahead. Hello?

Ms. Mancilla: Thank you.

Dr. Harper: You're welcome. Next question please.

Operator: Your next question comes from Betsy Clure.

Ms. Clure: We were trying to work on the dialysis requirement on the 837 professional, and we're having trouble figuring out exactly when we need to send some of these that are specifically for dialysis, like the weight. That one is not as hard. But claims and encounters involving Epitense for patients on dialysis. Exactly which situations would that be? Would it be only when you are actually billing for Epitense, and the diagnosis is an ESRD diagnosis or one of the other dialysis diagnoses, and then you have the measurements for hemoglobin, adequate and so forth, and it says required on service on dialysis for ESRD. Are those specific CPT codes combined with diagnosis or one or the other? And the same for the date of the last serum creatonine and hemoglobin and so forth. We're just having trouble figuring out exactly when this should be sent.

Mr. Nachimson: You're saying that the situational note is not specific enough?

Ms. Clure: No, because – I thought it would be. I'm a technical person, but I'm going to my clinical users and they're asking me questions I can't answer. They say, well, what about this situation and this

one? So we need to know whether this is a specific diagnosis that requires this or is it a combination of CPT's and diagnosis. And I don't know how to find out that answer.

Female Speaker: Are you billing through Medicare?

Ms. Clure: Yes.

Female Speaker: Okay. Because I know we require this information on initial EPO claims.

Ms. Clure: But it doesn't say that except for on the dates. Let's see, which one says initial. And I had one other quick question that I called in to the regional roundtable recently. They said that there would be some further instructions coming for the Medicare secondary electronic instructions. Because I asked a question about what if you get your initial payor information on paper, and they use the old codes. They're proprietary codes. What do you send Medicare for the claim adjustment reason code if you send it electronically? So they said they thought there were going to be some further instructions coming about that. Do you know when they would be coming?

Dr. Harper: We're have consultations around the table. Just a minute please.

Ms. Trudel: We'll have to check with our MSP people. We can call you back on that as well. I'm not sure.

Ms. Clure: And thank you.

Ms. Trudel: And again, the MSP issue is one of the ones that's involved in the electronic billing regulations that is still in process.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Christopher Fear.

Mr. Fear: Hi. I'd like to ask a question about direct data entry services. Is it permissible for a clearinghouse to operate a web-based DDE service for providers, and the service would take the DDE data, which could be standard or non-standard content and condition, assemble it into a valid 837 on behalf of the provider, and then transmit the 837 to a payor? My understanding is that the DDE

exception is for providers essentially typing directly on the payor's computer. But in this case the justification for this clearinghouse essentially providing this DDE service is that the clearinghouse would at that moment be functioning as a mere extension of the providers business. And so to use what has come to be known as the temp theory, the exchange, the doctor typing on the DDE service to the clearinghouse would essentially be taking place within the provider tent. So therefore none of the DDE requirements for content condition would apply.

Mr. Nachimson: The situation that you described is permissible, again assuming that the clearinghouse is functioning as a business associate of the provider, and then creating a valid and compliant 837 transaction and sending it forward to the health plan.

Mr. Fear: What if this clearinghouse – how do we determine whether it's a business agent of the provider if it's also the business agent of a one and only – one payor?

Mr. Nachimson: There would have to be some sort of an agreement signed between the provider and the clearinghouse establishing the roles and responsibilities of each, and basically ascertaining that this clearinghouse is serving as a business associate of the provider, and meeting the appropriate responsibilities of a business associate for that provider. If the clearinghouse was serving as a business associate to both, that's certainly still permitted, but the 837 transaction still has to come into existence at some point during the transition from provider to health plan.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Roger Ashley.

Mr. Ashley: My question was also on the National Drug Code, and it's been answered, so thank you.

Dr. Harper: Thank you, Mr. Ashley. Next question please.

Operator: Your next question comes from Joseph Spencer.

Mr. Spencer: Good afternoon.

Dr. Harper: Good afternoon to you.

Mr. Spencer: My question is concerning health plans. And we're running into a series of health plans that seem to interpret compliance by October 16th, meaning that they have remediated their system sufficiently that they can start testing post-October 16th. Will the Secretary be addressing or clarifying what it means to be compliant and ready for October 16th so that the health community or the insurance community isn't effected negatively as far as the cash flow and some of these health plans now waiting to start tests on October 16th, and we can't send electronic transactions unless it's the standard, and we don't want to do paper because that's additional work.

Ms. Trudel: We understand that. This is Karen Trudel again. This is one of the issues that many organizations have asked the Department of Health and Human Services to take a look at. We're very sensitive to the fact that adequate testing time is necessary, and we have for some time, and continue to advocate to all health plans to open up their testing as soon as they possibly can, and have been trying to model that behavior with Medicare fee for service.

Mr. Spencer: The question though that certainly at this point compliance means the ability to accept and process HIPAA compliant transactions on October 16, 2003? Would that statement be emphasized by the Secretary to the community because we're not hearing that same understanding.

Ms. Trudel: We expect that we're going to need to do a great deal of additional outreach this summer to make sure that everyone understands what their roles are. And, yes, I think that would be part of that outreach.

Mr. Spencer: Thank you.

Dr. Harper: Thank you, Mr. Spencer. Next question please.

Operator: Your next question comes from Catherine Benedict.

Ms. Benedict: Good day. Thank you very much. I wanted to just confirm that you're saying that the Part B carriers from Medicare are already doing testing and ready to take more testing. Have you confirmed that they are also accessing test files in the 837 format from Medicaid agencies that would involve the COB transactions?

Female Speaker: We're testing that - Medicaid is sending out the COB. We do not receive COB from Medicaid. We send it out to Medicaid.

Female Speaker: Medicaid is the last payor in the chain.

Female Speaker: We are testing when requested, yes.

Ms. Benedict: Okay. So for Medicaid reformation claims that are currently done electronically back to the Part B carriers, we should be able to start testing?

Female Speaker: You're talking about subrogation.

Ms. Benedict: Yes.

Female Speaker: And that is not a HIPAA transaction.

Dr. Harper: Thank you very much. Next question please.

Operator: Your next question comes from Peggy Lee Compton.

Ms. Compton: Hi. We have a question about the deadline as far as October 16th. Our site Medicaid office has told us that if the date of service is before October 16th, then we still have to use the local codes.

Ms. Trudel: You don't have to, but you may.

Ms. Compton: Okay. You may. But you can use the national codes instead that are required by HIPAA?

Ms. Trudel: Yes, if the payor and the provider agree that that is the condition, you can use the standard codes prior to October 16, but you don't have to.

Ms. Compton: So we can use the now approved national codes.

Female Speaker: Wait a minute. Are you saying that your state Medicaid program said that they can't do that?

Ms. Compton: Yes. Our state Medicaid program, at a workshop that I went to recently, said that if it's a base of service before October 16th, then you need to use the codes that were in effect before October 16th.

Ms. Trudel: Okay.

Mr. Nachimson: That's correct.

Ms. Compton: But can we use the national codes with those instead?

Ms. Trudel: If they're telling you that they cannot process it that way, then they are requesting you to use the old codes, so that's probably what you need to do.

Ms. Compton: Okay. Thanks.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from James Miller.

Mr. Miller: I'd like to revisit the issue on this NDC code issue with state Medicaid agencies. It was my understanding that when CMS repealed NDC as the standard medical data code set for reporting drugs and biologicals back in February, that one of the principle reasons was the high cost of converting offset by a minimal benefit to all the entities. For us to convert that kind of information for a state Medicaid agency only, we would still have to incur that cost, so I don't really understand the logic in allowing state agencies to have that latitude, whereas Medicare and other payors don't. Could you explain that please?

Ms. Trudel: Yes, this is Karen Trudel. Let me explain what went into that. What we found when we took an additional look was that there were essentially two schools of thought existing. One group of plans were using the HCPCS codes and didn't need to convert to the NDC code. Another group, and this does include a number of Medicaid state programs, were already using the NDC because they needed them for drug rebate purposes. And so what we have done is to try to maintain the status quo, and to permit both the NDC and HCPCS to be acceptable alternatives. And I'm sure there may be some situations – I'm personally not aware of any – where states that were using HCPCS codes are now implementing NDC. But I believe for the most part what we have here is a status quo.

Mr. Miller: In our state the non-retail pharmacies have traditionally used

HCPCS, and there was no use of the NDC. NDC's were used in the retail pharmacy arena. Now our state agency is requiring the NDC's on the non-retail pharmacy, which is contrary to your repeal back in February.

Ms. Trudel: It's not contrary to the repeal because what we found was that there weren't across the board, overwhelming business need for the NDC that were sufficient to justify having everyone convert to it. That is not to say that we don't accept that there are some compelling business needs for some plans to use the National Drug Code, and in those situations, then the plan does have the option to go ahead and implement.

Mr. Miller: Okay. We'll pursue this at the local level. Thank you.

Dr. Harper: Thank you, Mr. Miller. Next question please.

Operator: Your next question comes from Ray Hester.

Mr. Hester: Two questions I guess would be good. Could you update us on the Medicaid status about the country? We often hear they're behind. Another issue – about two calls ago you asked for obstacles, and something we put into HIPAA was HCPCS. There seems to be four sources. The Federal Register publishes them, your program memorandums publish them. There's the HCPCS book and the HCPCS website. And none of those four sources seem to be in sync.

Ms. Trudel: Let me take the HCPCS one first and then I'll let Marie handle the Medicaid one. I'll take that back to the code set maintainers, but I believe what we have is a situation where in some cases they're not in synch because, for instance, the regulations are only published periodically. I think the regulation HCPCS only go in once a year. The website is kept rather up to date, and I would suggest that that would be the first place that you would want to go.

Mr. Hester: I guess I disagree. We can send you specific examples if you want them. That's not the case.

Ms. Trudel: Mr. Hester, we'll go back and see if we can pull that out and take a look at it.

Dr. Harper: Any other comments in the room about this? Fine.

Female Speaker: Your initial question about the Medicaid agencies being behind or not ready, we are still monitoring the situation nationally. All states have reported that they will be compliant with their 837's and 835's by October 16th. We are doing our best to keep track of problematic situations and do what we can to alleviate those.

Dr. Harper: Thank you. Next question please.

Operator: Your next question comes from Mark Goldstone.

Mr. Goldstone: Hi. I've got a question on the privacy side of the house. My question has to do with the provision of the notice of privacy practices in emergency situations and obtaining acknowledgements. We've had a little bit of experience with this now, and since I represent emergency care providers, we're coming under a lot of fire wondering what do we do with patients whom we perceive to have a medical emergency. One of the issues is, of course, documenting the fact that we provided it. And we understand that we don't have to provide it until after the emergency has passed, but in a lot of cases, we don't have the patient in our possession at that point. And so my advice to my clients in a lot of cases is you can send it out certified, and then at least that way if they don't get it, you could document your good faith efforts, and you'll be backed up by the green card. My question is what modicum of documentation is OCR going to want to see if a patient claims I had an emergency and they never sent me the NPP? Do you want to see a green card, vis-à-vis, return mail? Are you just happy enough to see our documentation of good faith – yes, we mailed it on this date, and we never got it back from the patient. Any guidance would really be appreciated. Thanks for taking the call.

Ms. Fimple: This is Kathleen Fimple. Just documentation that you mailed it and that you made a good faith effort. You could ask them to – you've got a little postcard in there, just for them to mail it back. If you have procedures for sending it out after post-emergency situations, that would be fine. That would satisfy us.

Mr. Goldstone: So the documentation could be just our handwritten notes, and it wouldn't necessarily require the notice of privacy practices to go out by certified mail. And even if the patient didn't return the

postcard, as long as we routinely sent them something and noted that sent it, then that would be okay?

Ms. Fimple: That would be okay.

Mr. Goldstone: I'm sorry, ma'am. I didn't get your last name. Could you just tell me what that is.

Ms. Fimple: Fimple, F-I-M-P-L-E.

Mr. Goldstone: Thank you so much, Kathleen. I appreciate your help.

Ms. Fimple: Sure.

Dr. Harper: Ms. Nelson, we have time for one more call please.

Operator: Your final question comes from Dwayne Widenhour.

Mr. Widenhour: Thank you for taking my call. With regard to the HIPAA requirement of retail pharmacies sending certain drugs to the DMERC does this requirement mean that drugs are no longer going to be billed with HCPCS codes and only billed with the NDC number?

Female Speaker: If you are a retail pharmacy submitting retail drug claims, they will have to be submitted on the NDC.

Mr. Widenhour: They will only use NDC.

Female Speaker: Yes, using the NDC.

Mr. Widenhour: Okay. No HCPCS codes whatsoever?

Female Speaker: Correct.

Mr. Widenhour: Okay. And that's effective October 16th.

Female Speaker: Correct.

Mr. Widenhour: Okay. Thank you very much.

Dr. Harper: Now we'd like to share some announcements with you. Ms. Johnson.

Ms. Johnson: Good afternoon everyone. We have a number of outreach tools in place to access your HIPAA information needs. One thing we have going on right now is a live HIPAA broadcast, and a recent addition to that is a security piece which has just been added. So we encourage you to take a look at that. There's also Power Point presentations which are downloadable at your company webcast. You can access it at www.eventscreens.com/com/cmf/tm_001. We also have a broadcast coming up on July 16th and July 30th from 2:00 o'clock going until 3:00 o'clock, Eastern Standard Time. Information on the satellite broadcast can be found at www.cms.hhs.gov/medlearn, and you would want to click on Satellite Broadcast. We're looking for host sites, so please, if you are a host site and you want to sponsor this broadcast, which is free to the public, please log on and sign up as a host site or you can also register as a participant. And if you experience difficulty, feel free to e-mail us at askHIPAA@cms.hhs.gov. And lastly, our toll free hot line in case you missed it is 866-282-0659.

Dr. Harper: Thank you very much. We want to thank you for participating in this roundtable today. We do regret any inconvenience you may have had relative to the technical aspects of this call. And I also want to thank the staff for their participation. The call is concluded now. Thank you very much.

Operator: This concludes the Centers for Medicare and Medicaid Services 10th National HIPAA Implementation Roundtable. You may now disconnect.